STATE OF CALIFORNIA

STANDARD AGREEMENT

STD 213 (DHS Rev 7/04)

Exhibit A1

REGISTRATION NUMBER	AGREEMENT NUMBER
	XX-XXXXX

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME (Also referred to as CDHS, DHS, or the State)

California Department of Health Services

CONTRACTOR'S NAME (Also referred to as Contractor)

2. The term of this Agreement is: August 1, 2006 through February 28, 2010
   Work will not begin until contract approval is received from DGS

3. The maximum amount of this Agreement is: **$** up to 12,000,000
   up to Twelve Million Dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	2 pages
Exhibit A, Attachment I – Scope of Work - Contract Performance	18 pages
Exhibit B – Payment Provisions	3 pages
Exhibit B, Attachment I – Special Payment Provisions	5 pages
Exhibit C * – General Terms and Conditions	GTC 1005
Exhibit D(F) – Special Terms and Conditions (Attached hereto as part of this agreement)	26 pages
Notwithstanding provisions 5, 6, 15, 16, 22, 23 and 30 which don not apply to this agreement	
Exhibit E – Additional Provisions	20 pages
Exhibit E, Attachment I – Location and Number of Beneficiaries	1 pages
Exhibit F – Contractor's Release	1 page
Exhibit G – HIPAA Business Associate Addendum	7 pages
Exhibit H – Glossary (Appendix 1 of the RFP)	6 pages

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at http://www.ols.dgs.ca.gov/Standard+Language.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*

BY *(Authorized Signature)* ✍

DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

ADDRESS

STATE OF CALIFORNIA

AGENCY NAME

California Department of Health Services

BY *(Authorized Signature)* ✍

DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

Terri L. Anderson, Chief, Contracts and Purchasing Services Section

ADDRESS

1501 Capitol Avenue, Suite 71.2101, MS 1403, P.O. Box 997413
Sacramento, CA 95899-7413

California Department of General Services Use Only

☐ Exempt per:

Exhibit A
Scope of Work

1. Service Overview

Contractor agrees to provide to the California Department of Health Services (CDHS) the services described herein.

The Contractor shall develop, test, implement and maintain a Disease Management Pilot Program (DMPP). Disease Management (DM) services will be provided to seniors and persons with disabilities (SPD) (aka aged, blind, and disabled (ABD)) and individuals age 22 and older with one or more of the following chronic diseases: atherosclerotic disease syndrome, congestive heart failure, diabetes, asthma, coronary artery disease, or chronic obstructive pulmonary disease.

The Contractor shall be responsible for, but not limited to, providing the following services:

a. Contract Administration
b. Management Information Systems (MIS)
c. Quality Improvement System (QIS)
d. Utilization Monitoring (UM)
e. Member Services
    1) Member Rights
    2) Marketing
    3) Scope of Services
    4) Access and Availability
f. Provider Services
g. Implementation Plan and Deliverables

2. Service Location

DMPP services shall be delivered to eligible beneficiaries that reside in portions of Los Angeles county and all of Alameda county. See Exhibit E, Attachment I for the specific service locations within Los Angeles county.

3. Service Hours

The health advice line will be operated 24 hours a day, 7 days a week. All other services shall be provided during normal Contractor working hours, Monday through Friday, excluding national holidays.

4. Project Representatives

A. The project representatives during the term of this agreement will be:

Exhibit A
Scope of Work

Department of Health Services	**Contractor**
CDHS Contract Manager – Grant Gassman Telephone: (916) 552-9797 Fax: (916) 552-9602 E-mail: GGassman@DHS.ca.gov	(TBD) Telephone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX E-mail: Xxxxxxxx@xxxxxxxx

B. Direct all inquiries to:

Department of Health Services	**Contractor**
Professional Services Unit Attention: Gail Meeks Mail Station Code 4601 1501 Capitol Avenue P.O. Box 997417 Sacramento, CA 95899-7417 Telephone: (916) 552-9797 Fax: (916) 552-9602 E-mail: GMeeks@DHS.ca.gov	Section or Unit Name (if applicable) Attention: (TBD) Street address & room number, if applicable P.O. Box Number (if applicable) City, State, Zip Code Telephone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX E-mail: Xxxxxxxx@xxxxxxxx

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this agreement.

5. Services to be Performed

The Contractor shall perform the services described in the attached Exhibit A, Attachment 1, entitled, Scope of Work – Contract Performance.

Exhibit A, Attachment I
Scope of Work - Contract Performance

A. Contract Administration

Contractor shall maintain the organizational and administrative capabilities to perform its duties and responsibilities under the Contract. This will include, at a minimum, the following:

1. Organization and Staffing

   Contractor shall maintain the organization and staffing for implementing and operating the Contract. Contractor shall ensure the following:

   a. Organization has an accountable governing body;

   b. Staffing in medical and other health services, and in fiscal and administrative services, is sufficient to result in the effective conduct of the organization's business; and

   c. Written procedures for the conduct of the business of the organization, which provides effective controls.

2. Medical Oversight

   a. Contractor shall ensure that medical decisions, including those by subcontractors, are not unduly influenced by fiscal and administrative management.

   b. Contractor shall maintain a physician as Medical Director whose responsibilities shall include, but not be limited to, the following:

      1) Ensuring that medical decisions are rendered by qualified medical personnel;

      2) Ensuring that medical decisions are not influenced by fiscal or administrative management considerations;

      3) Ensuring that medical protocols and rules of conduct for medical personnel are followed;

      4) Resolving disputes related to the Member and provider services; and,

      5) Direct involvement in the implementation of Quality Improvement activities.

   c. Contractor shall report to CDHS any changes in the status of the Medical Director within ten (10) calendar days.

3. Reporting Requirements

Many of the data elements required below may be combined into grouped reports of related elements. Additionally, the Contractor may use electronic spreadsheets to track and report necessary data elements. All reports provided to CDHS must be user friendly (easily viewable and printable) and not contain excessive amounts of unsolicited data. The Contractor will submit the following reports:

a. Monthly Reports

The Contractor shall send monthly reports to CDHS that include the following information. CDHS must receive these monthly reports by the tenth calendar day of each month.

1) Identification of potential Members, including but not limited to the listing provided by CDHS, and the method and date of initial contact with the potential Member;

2) Identification of Members enrolled in the DMPP, or the date the Potential Member opted-out;

3) Identification of Provider/Primary Care Provider (PCP) providing DM services to DM Members;

4) Identification of individual Member 30-day evaluation due dates and completion dates;

5) Identification of individual Member 90-day Individual Treatment Plan (ITP) deadline date and ITP initiation date;

6) Identification of Members who have been disenrolled, disenrollment date and the reasons for disenrollment. (This report is intended to report disenrollments after they have occurred. All Contractor requests for disenrollment must be approved by CDHS through a separate process. See Member Services - Scope of Services - Enrollment/Disenrollment below);

7) Health advice line activity, including the number and type of calls; and

8) Other reports to be determined by CDHS.

b. Quarterly Reports

The Contractor shall send quarterly reports to CDHS that include the following information. CDHS must receive these quarterly reports within thirty (30) calendar days after the end of the quarter.

1) Provider training;

2) Incidence of sentinel events and mortality; and

3) Other reports to be determined by CDHS.

c. Semi-Annual Reports

The Contractor shall send semi-annual reports to CDHS that include the following information. CDHS must receive semi-annual reports within thirty (30) calendar days after the end of each 6-month period:

1) Member status reports and

2) Other reports to be determined by CDHS.

d. Annual Report

The Contractor shall send annual reports to CDHS that including the following information. CDHS must receive these annual reports within thirty (30) calendar days after the end of each 12-month period:

1) Quality improvement summary;

2) Contractor operational self-assessment; and

3) Other reports to be determined by CDHS.

B. MANAGEMENT INFORMATION SYSTEMS

1. Management Information System

Contractor's Management Information System (MIS) shall have processes that support the interactions between Financial; Member and Provider; Eligibility; Encounter Claims; Quality Improvement; Utilization Monitoring and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful. Contractor shall develop and maintain a MIS that provides, at a minimum:

a. CDHS reporting requirements as specified in Provision A.3;

b. All DMPP eligibility data;

c. Information on Members enrolled in the DMPP, such as, Member assessments, status, case management activities, and outcomes;

d. Financial information as specified in Exhibit E, Additional Provisions; and

e. Drug utilization data sufficient to identify under and/or over utilization of medication.

2. MIS/Data Correspondence

   Upon receipt of written notice by CDHS of any problems related to the submittal of data to CDHS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to CDHS a Corrective Action Plan with measurable benchmarks within thirty (30) calendar days from the date of the postmark of CDHS' written notice to Contractor. Within thirty (30) calendar days of CDHS' receipt of Contractor's Corrective Action Plan, CDHS shall approve the Corrective Action Plan or request revisions. Within fifteen (15) calendar days after receipt of a request for revisions to the Corrective Action Plan, Contractor shall submit a revised Corrective Action Plan for CDHS approval.

3. Health Insurance Portability and Accountability Act of 1996 (HIPPA)

   Contractor shall comply with Exhibit G - Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements and all federal and State regulations promulgated from this Act, as they become effective.

C. QUALITY IMPROVEMENT SYSTEM

1. General Requirements

   Contractor shall implement an effective Quality Improvement System (QIS) in accordance with nationally recognized disease management accrediting standards. Contractor shall monitor and evaluate all services delivered to Members to ensure contract requirements are met and to evaluate quality of DM services rendered. Contractor shall be accountable to address any needed improvements in meeting contract requirements, DM goals, and improvements in quality of DM services regardless of the number of contracting and subcontracting layers between the Contractor and Member. This provision does not create a cause of action against the Contractor on behalf of a DMPP Member for malpractice committed by a Subcontractor.

2. Written Description

   Contractor shall develop and implement a written description of its QIS that shall include the following:

   a. Organizational commitment to the delivery of quality DM services as evidenced by goals and objectives, which are approved by Contractor's governing body and periodically evaluated and updated;

   b. System for provider review of QIS findings, which at a minimum, demonstrates provider and other appropriate professional involvement and includes provisions for providing feedback to staff and providers regarding QIS study outcomes; and

c. Activities designed to assure the provision of case management and coordination of services.

3. Delegation of Quality Improvement Activities

a. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Monitoring, reports, and outcome measures) that are delegated to Subcontractor(s). If Contractor delegates quality improvement functions, Contractor and delegated entity (Subcontractor) shall include in their Subcontract, at a minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Subcontractor;

2) Contractor's oversight, monitoring, and evaluation processes and Subcontractor's agreement to such processes;

3) Contractor's reporting requirements and approval processes. The agreement shall include Subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and

4) Contractor's action/remedies if Subcontractor's obligations are not met.

b. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

1) Evaluates, on an annual basis, the Subcontractor's ability to perform the delegated activities including an initial review to assure that the Subcontractor has the administrative capacity, task, experience, and budgetary resources to fulfill its responsibilities;

2) Ensures Subcontractor meets standards set forth by Contractor and CDHS; and

3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

4. Quality Improvement Annual Report

Contractor shall develop a quality improvement report for submission to CDHS on an annual basis. The annual report shall include:

a. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; clinical outcome measures as listed in Appendix 4; and outcomes/findings from Quality Improvement projects.

b. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA, URAC) relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

c. An assessment of subcontractor's performance of delegated quality improvement activities.

5. Provider Participation

   Contractor shall maintain and implement appropriate procedures to keep providers serving DM Members informed of the written QIS, its activities, and outcomes.

6. Monitoring and Evaluation

   CDHS will arrange for an independent assessment/evaluation of the DMPP. The measures to be evaluated will include, but not be limited to, cost effectiveness and process and outcome measures for clinical, financial, humanistic, program implementation and plan operation variables. The evaluation shall estimate the projected savings, if any, in the budgets of State and Local governments if a DM benefit was expanded statewide. The Contractor will cooperate with the independent assessment/evaluation process.

D. UTILIZATION MONITORING

Utilization Monitoring (UM) allows an organization to monitor the provision of services. Reports and data on service utilization can provide the Contractor with vital information about the delivery of services. Utilization data can determine where health care dollars are being spent, which health care practitioners are providing the most appropriate health care, where Medi-Cal beneficiaries seem to prefer to access health care services, what services are being accessed, and what services may be utilized or delivered inappropriately. The DMPP emphasizes utilization monitoring as an important tool in detecting areas that need improvement.

Contractor shall develop and implement strategies based on utilization monitoring to minimize under/over utilization of emergency department services, acute care hospitalizations, specialist services, medication and other goods and services. At a minimum, the Contractor will track and trend the following:

1. Utilization per member per month in total, by diagnosis and type of service.

2. Gaps in care (recommended treatment/preventive care versus actual treatment).

3. Inappropriate use of medications (per applicable clinical guidelines).

Contractor will not have the authority to approve, modify or deny services to Members. All Treatment Authorization Requests (TARs) will be processed through the existing Medi-Cal prior authorization system.

E. MEMBER SERVICES – MEMBERS RIGHTS

1. Member Rights and Responsibilities

   Contractor shall develop, implement and maintain written policies that address Member rights and responsibilities and shall communicate these to its Members.

   a. Contractor's written policies regarding Member rights shall include the following:

      1) To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information;

      2) CDHS approved policy for resolving disputes;

      3) To be provided with information about the organization and its services;

      4) To receive oral interpretation services for identified threshold languages as listed in Appendix 1-Glossary;

      5) To have access to, and when legally appropriate, receive copies of, amend or correct their Member Record;

      6) To disenroll at any time;

      7) To receive written materials in alternative formats, including Braille, large size print, and audio format within 14 days of request; and

      8) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

   b. Contractor's written policy regarding Member responsibilities shall include, but not limited to, the following:

      1) Providing accurate information to staff;

      2) Treating staff with respect;

      3) Cooperating with case management processes;

      4) Participating in the development and the implementation of their ITP; and

      5) Cooperating with their health care providers.

c. Contractor shall implement and maintain policies and procedures to ensure the Member's right to confidentiality of medical information.

   1) Contractor shall implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons.

   2) Contractor shall inform Members of their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such authorization is not required.

d. Contractor shall maintain the capability to provide Member services to DMPP Members through sufficient assigned and knowledgeable staff.

e. Contractor shall ensure Member services staff is trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.

f. Contractor shall provide all new DMPP Members with written Member information. In addition, the Contractor shall provide potential Members with written Member information upon request.

   1) Contractor shall distribute the Member information no later than seven (7) calendar days after the effective date of the Member's Enrollment. Contractor shall revise this information, and distribute it annually to each Member.

   2) Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate by existing Medi-Cal standards.

   3) The written member informing materials shall be translated into the identified threshold languages (Provision H - Member Services, Access and Availability, Linguistic Services).

   4) The written member informing materials shall be provided in alternative formats, including Braille, large size print, and audio format, within 14 days of request.

g. Contractor shall develop and provide each Member a Member Services Guide that constitutes a fair disclosure of the provisions of the covered DM services. The Member Services Guide shall be submitted to CDHS for review and subsequent approval prior to distribution to Members. The Member Services Guide shall include the following information:

   1) Description of the DMPP covered services and benefits and how to access them;

   2) The importance of establishing a medical home and information on how to contact the DMO for assistance in this process;

3) Information explaining the importance and value of scheduling and keeping appointments;

4) Procedures for obtaining emergency health care;

5) Procedures for obtaining any transportation services available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available;

6) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Provision G - Member Services – Scope of Services, Enrollment/Disenrollment;

7) Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time;

8) Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Clinics (FQHC) and Rural Health Clinics (RHC); and

9) Any other information determined by CDHS to be essential for the proper receipt of DM services.

2. Member's Records

Contractor shall develop, implement and maintain written procedures pertaining to Member's records that address the following areas:

a. Collection, processing, maintenance, storage, retrieval, identification, and distribution;

b. Ensuring that Member's records are protected and confidential in accordance with all Federal and State laws;

c. Release of information; and

d. Ensuring the maintenance of Member's records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

Exhibit A, Attachment I
Scope of Work - Contract Performance

F. MEMBER SERVICES - MARKETING

1. Marketing Plan

Contractor shall develop a marketing plan as specified below. The marketing plan shall be specific to the DM Program only. Contractor shall implement and maintain the marketing plan only after approval from CDHS. Contractor shall ensure that the marketing plan, procedures, and materials are accurate and do not mislead, confuse, or defraud.

Contractor shall submit a marketing plan to CDHS for review and approval on an annual basis. The marketing plan, whether new, revised, or updated, shall describe the Contractor's current marketing procedures, activities, and methods. No marketing activity shall occur until the marketing plan has been approved by CDHS.

The marketing plan shall have a table of contents section that divides the marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections, or pages when revised, can be easily identified and replaced with revised submissions.

Contractor's marketing plan shall contain the following items and exhibits:

a. Mission Statement or Statement of Purpose for the marketing plan;

b. Organizational chart and narrative description; and

The organizational chart shall include the marketing director's name, address, telephone and facsimile number and key staff positions.

The description shall explain how the Contractor's internal marketing department operates, identifying key staff positions, roles and responsibilities, and reporting relationships.

c. Marketing Locations

All sites for proposed marketing activities such as annual health fairs, and community events, in which the Contractor proposes to participate, shall be listed.

d. Marketing Activities

All marketing methods and activities Contractor expects to use, or participate in, shall be described.

Contractor shall include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a marketing activity together and certify or otherwise demonstrate that permission for use of the marketing activity/event site has been granted.

e. Marketing Materials

Copies of all marketing materials the Contractor will use for both English and non-English speaking populations shall be included.

f. Marketing Distribution Methods

A description of the methods the Contractor will use for distributing marketing materials shall be included.

2. Miscellaneous

CDHS reserves the right to review, approve and/or deny all marketing activities. In addition, CDHS reserves the right to request additional documentation as needed to assess the Contractor's marketing program.

G. MEMBER SERVICES - SCOPE OF SERVICES

Contractor shall provide or arrange for all DM covered services to DMPP Members. Contractor will develop policies and procedures to provide administrative case management services, which include outreach and assessment; enrollment/disenrollment; case management; health advice line; assistance in finding a medical home; and member education. Contractor will assist Members with referrals to appropriate medical and community services, including specialty care.

1. Outreach and Assessment

a. Outreach

Contractor will develop policies and procedures for outreach to Members, providers and community resources regarding program information and operation.

b. Assessment

Members enrolled in the DMPP must be assessed initially and periodically, not less than annually, for information about their medical/health condition including, history, psycho-social status, medication, and service needs. The assessment shall form the basis for developing an ITP and determine the type and intensity of interventions that are appropriate. The Member Assessment will be completed within sixty (60) days of enrollment, and updated at periodic intervals, not less than annually, based on risk level. Assessment information may be compiled from various sources, including but not limited to, claims data, medical record review or survey methodology but shall not be obtained through the provision of face-to-face direct clinical medical services from the DMO.

Exhibit A, Attachment I
Scope of Work - Contract Performance

2. Enrollment/Disenrollment

CDHS will supply the Contractor with a monthly list of potential Members. The contractor must make a good faith effort to contact all potential Members with information regarding the DMPP benefits, services and enrollment/disenrollment procedures. Once the list is exhausted, CDHS will supply additional lists as necessary. If a potential Member chooses not to be enrolled, they will have thirty (30) days to opt-out of the program from the initial contact date. At the beginning of the first month following the end of the 30-day opt-out period, the potential Members who have not opted-out will be enrolled as Members.

The Contractor shall enroll a minimum of 250 DMPP Members in each of the six disease categories in each county in each year of the operations period of the contract. The purpose of this requirement is to ensure that there is a statistically valid sample size to evaluate for each disease in each pilot county. There are no enrollment distribution mandates beyond this minimum enrollment requirement.

During the program implementation phase, the Contractor shall have an additional two months to complete each phase of the enrollment and initial services for the potential Members, including initial contact, enrollment, Member assessment, and ITP development and implementation.

The DMPP will provide disease management services to those persons who meet all of the following requirements:

a. Are Medi-Cal eligible;
b. Are 22 years of age or older;
c. Have a primary or secondary diagnosis of:
    1. Artherosclerotic disease syndrome;
    2. Congestive heart failure (CHF);
    3. Coronary artery disease (CAD);
    4. Diabetes mellitus (Diabetes);
    5. Asthma; or
    6. Chronic obstructive pulmonary disease (COPD)

All Medi-Cal beneficiaries who meet the qualifications noted above will be considered eligible for the DMPP, except those who:

- Have restricted/emergency only Medi-Cal;
- Are Medicare eligible;
- Have other insurance that provides comparable DM services (e.g., Medi-Cal Managed Care);
- Reside in nursing facilities (NF);
- Reside in all levels of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Have a Medi-Cal eligibility period that is less than 3 months;
- Have a Medi-Cal eligibility period that is only retroactive;
- Are eligible as medically needy;
- Are Native American;

- Participate in Medicaid waiver programs, including Home and Community Based, Freedom of Choice and Research and Demonstration waivers, but not including the Hospital Financing/Mental Health waiver;
- Receive comparable case management services from another program such Medical Case Management;
- Have a primary or secondary diagnosis of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome; or
- Receive services related to transplants, cancer, severe trauma, end stage renal disease, and/or hospice.

As part of the enrollment process noted below, CDHS will screen out Medi-Cal beneficiaries who are not eligible for the program by generating a list of potential Members according to the appropriate aid codes and ICD-9 codes.

Members shall be admitted to the DMPP based on the quotas as described in G.2 above. Member quotas will be limited by the availability of funding and statistically valid sample for each disease condition and adequate geographic distribution. If membership exceeds DMPP availability, CDHS will develop and implement a process for enrollment through a waiting list.

A Member who, during the time of DMPP membership, enters a nursing facility for a short-term stay of thirty (30) days or less will not be disenrolled except at the Member's request. A Member who, after enrolling in the DMPP, begins receiving treatment for transplants, cancer, end stage renal disease, or severe trauma, will only be disenrolled from the DMPP at the Member's request or in cases where services are duplicated.

The Contractor shall complete a Member Assessment within sixty (60) days from the date of enrollment. Through the Member assessment, the Contractor shall determine the Member's health status and include confirmation that the Member is qualified for the program (i.e. diagnosed with one of the identified disease conditions). If the Contractor determines that the Member is not medically qualified for the program, as noted above, the Contractor shall coordinate disenrollment with the Contract Administrator. CDHS shall retain control of disenrollment from the DMPP.

Within seven (7) business days of receiving a request for disenrollment of a Member or potential Member from the Contractor or beneficiary, CDHS will make a determination and notify the Contractor. Subsequently, the Contractor shall notify the Member or potential Member within seven (7) business days of the disenrollment or denial of a request for enrollment with a Notice containing, at a minimum, the following information:

a. Action taken by the Contractor; and

b. Reason for the action taken.

Members will have the option to end their enrollment each month. To request disenrollment, Members shall notify the Contractor verbally or in writing. The Contractor shall notify CDHS within two (2) business days of the Member's

request. Disenrollment will occur on the first day of the month following the month the request was made. Former Members who disenrolled voluntarily may reenroll at any time by making a verbal or written request to the Contractor. Reenrollment will take place on the first day of the month following the month the reenrollment request is made.

3. Disease/Case Management

The Contractor will adopt DM standards to improve the health of Members by providing services based on evidence-based practice guidelines to include: promoting collaborative relationships with providers, providing Member and provider education, and employing reporting and feedback loops for decision making with providers and Members.

The Contractor will ensure continuity of care in collaboration with the provider/PCP by:

a. Monitoring the referral and follow-up of Members in need of specialty care and routine health care services;
b. Documentation of referral and follow-up services in Member's record;
c. Documentation in Member's record of emergency medical encounters with the appropriate follow-up as medically indicated; and
d. Documentation and follow-up in Member's record of planned health care services.

Disease/case management activities should include, but are not limited to the following:

a. Medication management – The Contractor shall develop and implement policies and procedures for the following elements:

    1) Medication profiling;

    2) Medication monitoring;

    3) Feedback to provider/PCP and/or pharmacist; and

    4) Member and provider education.

b. ITP - Based on the Member assessment, the Contractor shall assure and coordinate the development of the ITP to be completed and in place within ninety (90) days of membership. The Member or the Member's designee, the provider/PCP and Case Manager should be actively involved in the development and periodic review of the ITP.

    The ITP must also include specific provisions for periodic (not less than semi-annually) review and updates to the plan as appropriate. Intervals of periodic review and ITP updates should be established based on the severity of the Member's condition.

Participants of the review should include, but not be limited to, the following:

1) Member;

2) Case Manager;

3) Provider/PCP; and

4) Representatives providing services to the Member as identified in the ITP (e.g. nutritionist or psychiatrist).

c. Coordination/Continuity of Care – Contractor shall develop and implement policies and procedures related to establishing relationships, developing referral processes, and sharing information with the provider/PCP, State, and Community agencies to enable Members to access needed services and ensure continuity of care.

The Contractor will establish and make available lines of communication to allow interaction between the Contractor, Member, and the provider/PCP.

d. Staffing - At a minimum, the Case Manager will be a licensed registered nurse or other healthcare professional as defined in Section 4999.2 of the California Business and Professions Code. The Contractor shall also employ the services of a licensed psychiatrist, psychologist, or licensed/certified mental health specialists, as needed, to address the behavioral and/or mental health concerns of the Member.

e. Member Advocacy – The ITP shall be developed and implemented to be Member-centered. The Contractor shall advocate on behalf of the member, as necessary, to ensure optimal care for the Member.

4. Health Advice Line

The Contractor must offer a twenty-four hour, seven days a week (24/7) toll-free health advice line staffed by health care professionals, as defined in California Business and Professions Code Section 4999.2. Operators of the advice line will provide general and personalized health care information (such as the DMPP Member's ITP, provider/PCP, accessing emergency services, and relevant utilization data). The advice line will also provide education and assistance for DMPP Members and/or their caregivers. This line must be operated in accordance with current managed care program rules for comparable advice lines, including provisions for interpreter services (Business and Professions Code Section 4999.2 and 4999.7 and Section 1348.8 of the Health and Safety Code).

The Contractor must develop and implement a timely method of communicating the Member telephone contact information with the Member's case manager and ensure the advice line is operated in an efficient and effective manner.

5. Member Education

   a. Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members.

   b. Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.

   c. Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience (See Glossary – Threshold Language).

   d. Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics:

      1) Appropriate use of health care services.

      2) Risk-reduction and healthy lifestyles.

      3) Self-care and management of health conditions.

   e. Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to maximize effectiveness.

   f. Contractor shall periodically, not less than annually, review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

H. MEMBER SERVICES - ACCESS AND AVAILABILITY

1. Access Requirements

   The Contractor shall establish accessibility standards, which include, but are not limited to, the following:

   a. Telephone Procedures

      Contractor shall maintain procedures for triaging Member's telephone calls, providing telephone advice and accessing telephone interpreters.

   b. Contractor shall ensure that all non-English-speaking, or limited English proficient (LEP) DMPP Members receive 24-hour oral interpreter services, either through interpreters or telephone language services. Contractor shall

arrange or provide, at minimum, the following linguistic services at no cost to the DMPP Members:

1) Fully translated written informational materials, including but not limited to the Member Service Guide, enrollee information, welcome packets, marketing information, and form letters. Contractor shall provide translated written informing materials to all non-English speaking or LEP members that speak the identified threshold language (See Glossary – Threshold Language), upon request.

2) Referrals to culturally and linguistically appropriate community service programs.

3) Telecommunications Device for the Deaf (TDD).

2. Changes in Availability or Location of DM Services

a. Contractor shall provide notification to CDHS sixty (60) calendar days prior to making any substantial change in the availability or location of services to be provided under this Contract. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to CDHS as soon as possible.

c. Contractor is not required to provide a service that it objects to on moral or religious grounds. If the service is disputed, the Contractor shall inform the Member of an alternate method of obtaining the service.

I. PROVIDER SERVICES

1. Provider Education

Contractor shall provide education to provider/PCP to include, but not be limited to, the following:

a. Contractor shall provide training to all providers/PCP that are treating DMPP Members for a DM qualifying disease. Contractor shall ensure this training includes information on all Member rights, Member services, and the right to actively participate in health care decisions.

b. Use of evidence-based practice guidelines.

c. Resource tools developed by the Contractor to facilitate the use of evidence-based practice guidelines by the provider/PCP.

d. Evaluation and appropriate treatment of mental health issues.

e. Identification and utilization of community resources.

2. Provider Feedback

   Contractor shall develop and implement system(s), which will provide information to the provider/PCP relating to Member's adherence to the ITP. Contractor shall employ feedback techniques to the provider/PCP to improve the quality and appropriateness of the care provided to the Member.

J. IMPLEMENTATION PLAN AND DELIVERABLES

The Implementation Plan and Deliverables section describes CDHS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning operations.

Once the Contract is awarded, the Contractor has fifteen (15) calendar days after its signs the Contract to submit a Workplan for each county that describes in detail how and when the Contractor will submit and complete the deliverables to CDHS. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plan(s) in the event of implementation delays.

The Contractor's workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. CDHS will review and approve each workplan(s). However, Contractor shall not delay the submission of deliverables required in the workplan(s) while waiting for CDHS approval of previously submitted deliverables required by the workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved CDHS workplan(s). In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved CDHS workplan(s), CDHS may impose Liquidated Damages in accordance with Exhibit E - Additional Provisions.

The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period (approximately 4 months after the effective date of the Contract). The Operations Period is the period of time beginning with the effective date of the first month of operations and continues through the last month of the services to the Members.

Upon successful completion of the Implementation Plan and Deliverables section requirements, CDHS will authorize, in writing, that the Contractor may begin the Operation Period. Phaseout requirements are identified in Exhibit E-Additional Provisions.

Exhibit B
Budget Detail and Payment Provisions

1. **Invoicing and Payment**

A. For services satisfactorily rendered, and upon receipt and approval of the invoices, the State agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Invoices shall include the Agreement Number and shall be submitted in triplicate not more frequently than monthly in arrears to:

Mr. Grant Gassman
California Department of Health Services
Medi-Cal Benefits Branch
MS 4601
P.O. Box 997413
Sacramento, CA 95899-7413

C. Invoices shall:

1) Be prepared on Contractor letterhead. If invoices are not on produced letterhead invoices must be signed by an authorized official, employee or agent certifying that the expenditures claimed represent actual expenses for the service performed under this contract.
2) Bear the Contractor's name as shown on the agreement.
3) Identify the billing and/or performance period covered by the invoice.
4) Itemize costs for the billing period in the same or greater level of detail as indicated in this agreement. Subject to the terms of this agreement, reimbursement may only be sought for those costs and/or cost categories expressly identified as allowable in this agreement and approved by CDHS.
5) Report expenses attributed to Disabled Veteran Business Enterprise (DVBE) subcontractors or DVBE suppliers at any tier (if any). This requirement only applies if the contractor identified DVBEs for participation during the selection or negotiation process.
6) Provide member enrollment report for the billing period.

2. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Contractor to reflect the reduced amount.

3. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

Exhibit B
Budget Detail and Payment Provisions

4. Amounts Payable

A. The amounts payable under this agreement shall not exceed:

1) Up to $4,000,000 for the budget period of 08/01/06 through 11/30/07 (16 months).
2) Up to $4,000,000 for the budget period of 12/01/07 through 11/30/08 (12 months).
3) Up to $4,000,000 for the budget period of 12/01/08 through 02/28/10 (15 months).

The maximum amount payable under this Contract shall be up to $12,000.000. Case Management Fee payments will only be paid for enrolled Members during the operations period.

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

C. The Contractor must maintain records reflecting actual expenditures for each state fiscal year covered by the term of this agreement.

5. Timely Submission of Final Invoice

A. A final undisputed invoice shall be submitted for payment no more than ninety (90) calendar days following the expiration or termination date of this agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said invoice should be clearly marked "Final Invoice", thus indicating that all payment obligations of the State under this agreement have ceased and that no further payments are due or outstanding.

B. The State may, at its discretion, choose not to honor any delinquent final invoice if the Contractor fails to obtain prior written State approval of an alternate final invoice submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.

C. The Contractor is hereby advised of its obligation to submit, with the final invoice, a "Contractor's Release" (Exhibit F) acknowledging submission of the final invoice to the State and certifying the approximate percentage amount, if any, of recycled products used in performance of this agreement.

6. Progress Payment Withholds

A. This provision replaces and supersedes provision 22 of Exhibit D(F).

B. Progress payments may not be made more frequently than monthly in arrears for work performed and costs incurred in the performance of the agreement. In the aggregate, progress payments may not exceed 90 percent of the total agreement amount, regardless of agreement length.

C. Ten percent (10%) may be withheld by CDHS from each invoice submitted for reimbursement, under the following conditions:

1) For services and costs associated with contractor and/or subcontractor performance that is considered to be of an ongoing nature or performed continuously throughout the term of the agreement.

2) For individual services associated with a specific agreement deliverable that has not yet been received or completed in its entirety.

3) For individual and/or distinct tasks, work plans, or project activities that have not yet been completed in their entirety.

D. Release of Amounts Withheld

As individual and/or distinct tasks, services, work plans, or project activities are completed in their entirety by either the Contractor or Subcontractor and any scheduled/required deliverables or reports are delivered to CDHS; then any funds so withheld may be released to the Contractor upon acceptance and/or acknowledgement that all such items have been completed to the full satisfaction of CDHS.

E. Payment Requests Excluded from the 10 Percent (10%) Withhold

Ten percent (10%) payment withholds shall not be applied to reimbursements or periodic payment requests for direct costs associated with equipment purchases, media buys, operating expense items, and other procurements not directly associated with the Contractor's personal performance.

7. Expense Allowability / Fiscal Documentation

A. Invoices, received from a Contractor and accepted and/or submitted for payment by the State, shall not be deemed evidence of allowable agreement costs.

B. Contractor shall maintain for review and audit and supply to CDHS upon request, adequate documentation of all expenses claimed pursuant to this agreement to permit a determination of expense allowability.

C. If the allowability or appropriateness of an expense cannot be determined by the State because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles or practices, all questionable costs may be disallowed and payment may be withheld by the State. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

8. Special Payment Provisions

Refer to attached Exhibit B, Attachment I for *Special Payment Provisions* specific to this contract.

Exhibit B, Attachment I
Special Payment Provisions

In the event of a conflict between the provisions of Exhibit B, Attachment I *Special Payment Provisions,* and Exhibit B *Budget Detail and Payment Provisions*, the provisions of Exhibit B, Attachment I shall govern.

1. Contractor Risk in Providing Services

The Contractor will assume total risk for providing the Covered Disease Management Services on the basis of the periodic case management fee for each Member, except as otherwise allowed in this Contract.

The Contractor will retain any monies not expended by the Contractor after having fulfilled these obligations under this Contract.

2. Case Management Fee Rates

DHS shall remit to the Contractor a post-paid case management fee each month for each Disease Management Pilot Program Member that appears on the approved list of Members supplied to DHS by the Contractor. The payment period for disease management services for each Member shall commence on the first day of the month following the month the Member is enrolled. Case management fees shall be reimbursed at the rate bid per member per month, subject to Provision 4, *Determination of Rates* listed below, in accordance with the Cost Proposal submitted in response to RFP 05-45889.

3. Case Management Fee Rates Constitute Payment in Full

The case management fee constitutes payment in full for all Covered Disease Management Services required by the Member and for all Administrative Costs incurred by the Contractor in providing for or arranging those services. It does not include payment for recoupment for current or previous losses by the Contractor. DHS is not responsible for making payment for recoupment of losses.

4. Determination of Rates

The case management fee shall be determined by competitive bid and be paid from the beginning of the contract operations period through the end of the operations period. All payments are subject to appropriations of funds by the Legislature and Department of Finance approval. Further, all payments are subject to Federal congressional appropriation of funds.

5. Obligation Changes

DHS and the Contractor may negotiate an earlier termination date, pursuant to Exhibit E, *Additional Provisions*, provision 3.C., *Termination for Cause and Other Terminations, Termination – Contractor*, if a change in contractual obligation is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the

Contractor entered into this Contract, such that the Contractor can demonstrate to the satisfaction of DHS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

6. Recovery of Case Management Fees

DHS shall have the right to recover from the Contractor amounts paid to the Contractor in the following circumstances as specified:

a. If DHS determines that a Member has either been improperly enrolled due to ineligibility of the member to enroll in the Contractor's plan, residence outside the Contractor's Service Area, or should have been disenrolled with an effective date in a prior month, DHS may recover the case management fees made to the Contractor for the Member. Or, upon request by the Contractor, DHS shall recover the case management fees made to the Contractor for the Member and release the Contractor from all financial and other risk for the provision of services to the Member under the terms of the Contract for the month(s) in question.

   Upon request by the Contractor, DHS may allow the Contractor to retain the case management fees made for Members that are eligible to enroll in the Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 1, provision G.2, Entitled Enrollment/Disenrollment, or under other circumstances as approved by the DHS. If the Contractor retains the case management fees, Contractor shall provide or arrange and pay for all necessary Covered Disease Management Services for the Member, until the Member is disenrolled on a non-retroactive basis.

b. As a result of the Contractor's failure to perform contractual responsibilities to comply with mandatory Federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHS to Contractor. DHS may recover the amount disallowed by DHHS by an offset to the case management fee made to the Contractor. If the recovery of the full amount at one time imposes a financial hardship on the Contractor, DHS at its discretion, may grant the Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months.

c. If DHS determines that any other erroneous or improper payment not mentioned above has been made to the Contractor, DHS may recover the amount determined by an offset to the case management fee made to Contractor. If the recovery of the full amount at one time imposes a financial hardship on the Contractor, DHS at its discretion, may grant the Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months.

Exhibit B, Attachment I
Special Payment Provisions

7. Invoicing and Payment Additional Requirements

The Invoicing and Payment requirements stated in Exhibit B, *Budget Detail and Payment Provisions,* Provision 1, entitled *Invoicing and Payment*, paragraph C, are minimum standards and additional billing information may be required as the project develops. Any additional requirements will be considered normal business operation and not require a contract amendment.

8. Savings Guarantee and Calculation Methodology

a. The Disease Management Organization (DMO) shall guarantee California Department of Health Services (CDHS) a zero percent increase in net medical costs for Medi-Cal members who are eligible for the Disease Management Pilot Program (DMPP). Restated, the DMO guarantees that the program will create savings equivalent to the DMPP contracted DMO fees. One hundred percent of the DMO's fees will be at risk for this guarantee of cost-neutrality. If CDHS terminates the contract in the first 16 months, the Contractor will be held to no guarantee. If CDHS terminates the contract after 16 months but before 28 months, the cost-neutrality guarantee will be changed to a guarantee to limit the net increase of medical costs to five percent. If CDHS terminates the contract after 28 months but before 43 months, the cost-neutrality guarantee will be changed to a guarantee to limit the net increase of medical costs to two and one-half percent.

b. The DMO's guarantee shall be proportionate, in that, as needed, the DMO shall refund its fees in the same proportion that the cost-neutrality target is missed. However, the DMO will not be liable for more than 100% of its fee.

c. DMPP savings are calculated using the following formula: Per member per month (PMPM) costs of the matched control group – PMPM costs of DMPP eligibles x DMPP eligible months.

d. Costs for Medi-Cal fee-for-service (FFS) beneficiaries without DM services will be estimated using the average (mean) PMPM total Medi-Cal costs of a matched control group. The matched control group will be selected from Medi-Cal FFS beneficiaries from outside the pilot areas who meet the DMPP eligibility criteria. The matched control group's membership will be determined through a propensity score matching method by a third-party evaluation contractor. (Propensity scores are predicted probabilities of program participation that can be generated for each DMPP member and each potential matched control group member.) Costs for DMPP eligibles in the pilot area and the matched control group will be determined by actual costs in the contract period after a six-month lag time for run-out claims. Per member costs of DMPP eligibles will include DMPP DMO fees paid (the fee is only paid for DMPP members, but for the guarantee calculation, the fee total will be added to the total medical costs of DMPP eligibles in the pilot areas and averaged).

e. The determination of costs for both the DMPP eligibles and the matched control group will follow the same algorithm. Cost comparisons shall be made on a PMPM basis, using the formula: *costs divided by member months*. Costs will be accumulated as total Medi-Cal expenditures during the operations period of the contract. Costs in the operations period of the contract will be included for months when that Medi-Cal member was eligible for the DMPP.

f. Member eligibility includes the full set of Medi-Cal FFS beneficiaries and reduces this population based on criteria specified by the CDHS. Based on Medi-Cal eligibility and other criteria, DMPP eligibles may lose or gain eligibility monthly.

g. Because this methodology uses a matched control group comparison, no baseline comparison is needed, and therefore no adjustment for inflation is required. There will also be no regression-adjustment for any disease because there is no baseline comparison involved. Because the DMPP eligible population is relatively large, no large single expenditures (outliers) will be removed from the calculation. Please note that the savings calculation is based on averaged PMPM expenses for the entire DMPP eligible population in the pilot area, and not just the DMPP members who receive services.

Exhibit B, Attachment I
Special Payment Provisions

9. Sample Savings Calculation

	Control Group	***DMPP Eligibles***	***Comments***
Contracted Fees and Guarantee			
Claims cost/month for three-year operations period	$500	$500	PMPM costs are measured from the first day of the operations period of the contract or the first day of the first month the eligible or member generated a claim.
Vendor fees		$40	Actual PMPM fee of $50 total for DMPP member-months and divided by DMPP eligible-months (for purposes of this sample, member months equal 80% of eligible months based on a hypothetical 80% enrollment rate).
Vendor guarantee		0.0% net	Negotiated ("net" refers to total costs with vendor fees included).
Vendor target		$500	0.0% reduction from $500 control group claims, including vendor fees
Calculated Performance			
Total actual claims	$500	$500	Calculated
Total actual cost	$500	$540	Claims plus fees, calculated
Did the Vendor Meet the Target			
Vendor performance versus target		$540 performance; $500 target	Net claims should have been $500 to meet the target.
Amount of miss		$40	
Payout by vendor to compensate for missing target		$40	Vendor refunds 100% of their fees.

Exhibit C
General Terms and Conditions

The State's General Terms and Conditions (GTC 1005) can only be viewed or downloaded from the following Internet site http://www.ols.dgs.ca.gov/Standard+Language/default.htm. [Rev. 10-04-05]

The General Terms and Conditions are modified from time to time by the California Department of General Services to comply with changes to federal or state law and the version that applies to the resulting agreement is determined based on the contract start date. DHS reserves the right to place into the resulting agreement a more current GTC version, when applicable.

If your firm does not have Internet access, please contact the program identified in the RFP cover letter to request a hard or paper copy of the General Term and Conditions.